



General Assembly

February Session, 2010

***Raised Bill No. 5219***

LCO No. 1023

\*01023\_\_\_\_\_INS\*

Referred to Committee on Insurance and Real Estate

Introduced by:  
(INS)

***AN ACT EXTENDING STATE CONTINUATION OF HEALTH  
INSURANCE COVERAGE.***

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 38a-538 of the general statutes is repealed and the  
2 following is substituted in lieu thereof (*Effective from passage*):

3 Each employer shall allow individuals to elect to continue coverage  
4 under a group plan pursuant to [federal extension requirements  
5 established by the Consolidated Omnibus Budget Reconciliation Act of  
6 1985 (P.L. 99-272), as amended] section 38a-554, as amended by this  
7 act.

8 Sec. 2. Section 38a-554 of the 2010 supplement to the general statutes  
9 is repealed and the following is substituted in lieu thereof (*Effective*  
10 *from passage*):

11 A group comprehensive health care plan shall contain the minimum  
12 standard benefits prescribed in section 38a-553 and shall also conform  
13 in substance to the requirements of this section.

14 (a) The plan shall be one under which the individuals eligible to be

15 covered include: (1) Each eligible employee; (2) the spouse of each  
16 eligible employee, who shall be considered a dependent for the  
17 purposes of this section; and (3) unmarried children who are under  
18 twenty-six years of age. Each plan shall cover a stepchild on the same  
19 basis as a biological child.

20 (b) The plan shall provide the option to continue coverage under  
21 each of the following circumstances until the individual is eligible for  
22 other group insurance, except as provided in subdivisions (3) and (4)  
23 of this subsection:

24 (1) Notwithstanding any provision of this section, upon layoff,  
25 reduction of hours, leave of absence [.] or termination of employment,  
26 other than as a result of death of the employee or as a result of such  
27 employee's "gross misconduct" as that term is used in 29 USC 1163(2),  
28 continuation of coverage for such employee and such employee's  
29 covered dependents for [the periods set forth for such event under  
30 federal extension requirements established by the federal Consolidated  
31 Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended  
32 from time to time] a period of thirty months after the date of such  
33 layoff, reduction of hours, leave of absence or termination of  
34 employment, except that if such reduction of hours, leave of absence or  
35 termination of employment results from an employee's eligibility to  
36 receive Social Security income, continuation of coverage for such  
37 employee and such employee's covered dependents until midnight of  
38 the day preceding such person's eligibility for benefits under Title  
39 XVIII of the Social Security Act;

40 (2) [upon] Upon the death of the employee, continuation of  
41 coverage for the covered dependents of such employee for the periods  
42 set forth for such event under federal extension requirements  
43 established by the Consolidated Omnibus Budget Reconciliation Act of  
44 1985, P.L. 99-272, as amended from time to time;

45 (3) [regardless] Regardless of the employee's or dependent's  
46 eligibility for other group insurance, during an employee's absence

47 due to illness or injury, continuation of coverage for such employee  
48 and such employee's covered dependents during continuance of such  
49 illness or injury or for up to twelve months from the beginning of such  
50 absence;

51 (4) [regardless] Regardless of an individual's eligibility for other  
52 group insurance, upon termination of the group plan, coverage for  
53 covered individuals who were totally disabled on the date of  
54 termination shall be continued without premium payment during the  
55 continuance of such disability for a period of twelve calendar months  
56 following the calendar month in which the plan was terminated,  
57 provided claim is submitted for coverage within one year of the  
58 termination of the plan;

59 (5) [the] The coverage of any covered individual shall terminate: (A)  
60 As to a child, the plan shall provide the option for said child to  
61 continue coverage for the longer of the following periods: (i) At the  
62 end of the month following the month in which the child: Marries;  
63 ceases to be a resident of the state; becomes covered under a group  
64 health plan through the dependent's own employment; or attains the  
65 age of twenty-six. The residency requirement shall not apply to  
66 dependent children under nineteen years of age or full-time students  
67 attending an accredited institution of higher education. If on the date  
68 specified for termination of coverage on a child, the child is unmarried  
69 and incapable of self-sustaining employment by reason of mental or  
70 physical handicap and chiefly dependent upon the employee for  
71 support and maintenance, the coverage on such child shall continue  
72 while the plan remains in force and the child remains in such  
73 condition, provided proof of such handicap is received by the carrier  
74 within thirty-one days of the date on which the child's coverage would  
75 have terminated in the absence of such incapacity. The carrier may  
76 require subsequent proof of the child's continued incapacity and  
77 dependency but not more often than once a year thereafter, or (ii) for  
78 the periods set forth for such child under federal extension  
79 requirements established by the Consolidated Omnibus Budget

80 Reconciliation Act of 1985, P.L. 99-272, as amended from time to time;  
81 (B) as to the employee's spouse, at the end of the month following the  
82 month in which a divorce, court-ordered annulment or legal  
83 separation is obtained, whichever is earlier, except that the plan shall  
84 provide the option for said spouse to continue coverage for the periods  
85 set forth for such events under federal extension requirements  
86 established by the Consolidated Omnibus Budget Reconciliation Act of  
87 1985, P.L. 99-272, as amended from time to time; and (C) as to the  
88 employee or dependent who is sixty-five years of age or older, as of  
89 midnight of the day preceding such person's eligibility for benefits  
90 under Title XVIII of the federal Social Security Act;

91 (6) [as] As to any other event listed as a "qualifying event" in 29 USC  
92 1163, as amended from time to time, continuation of coverage for such  
93 periods set forth for such event in 29 USC 1162, as amended from time  
94 to time, provided such plan may require the individual whose  
95 coverage is to be continued to pay up to the percentage of the  
96 applicable premium as specified for such event in 29 USC 1162, as  
97 amended from time to time.

98 Any continuation of coverage required by this section except  
99 subdivision (4) or (6) of this subsection may be subject to the  
100 requirement, on the part of the individual whose coverage is to be  
101 continued, that such individual contribute that portion of the premium  
102 the individual would have been required to contribute had the  
103 employee remained an active covered employee, except that the  
104 individual may be required to pay up to one hundred two per cent of  
105 the entire premium at the group rate if coverage is continued in  
106 accordance with subdivision (1), (2) or (5) of this subsection. The  
107 employer shall not be legally obligated by sections 38a-505, 38a-546  
108 and 38a-551 to 38a-559, inclusive, as amended by this act, to pay such  
109 premium if not paid timely by the employee.

110 (c) The commissioner shall adopt regulations, in accordance with  
111 chapter 54, concerning coordination of benefits between the plan and

112 other health insurance plans. No individual or group health insurance  
113 plan shall coordinate benefits or otherwise reduce benefit payments  
114 because a person is covered by or receives benefits from a group  
115 specified disease policy delivered, issued for delivery, renewed,  
116 amended or continued in this state.

117 (d) The plan shall make available to Connecticut residents, in  
118 addition to any other conversion privilege available, a conversion  
119 privilege under which coverage shall be available immediately upon  
120 termination of coverage under the group plan. The terms and benefits  
121 offered under the conversion benefits shall be at least equal to the  
122 terms and benefits of an individual comprehensive health care plan.

123 (e) (1) The provisions of subdivision (1) of subsection (b) shall apply  
124 to any individual who has elected or elects continuation of coverage  
125 pursuant to this section on or after the effective date of this section.

126 (2) Each insurer and health care center that has issued a group  
127 health insurance policy subject to sections 38a-546 and 38a-554, as  
128 amended by this act, shall, in conjunction with their group  
129 policyholders, including employers with fewer than twenty  
130 employees, provide notice not later than sixty days after the effective  
131 date of this section to such individuals set forth in subdivision (1) of  
132 this subsection.

133 Sec. 3. Section 31-51o of the general statutes is repealed and the  
134 following is substituted in lieu thereof (*Effective from passage*):

135 (a) Whenever a relocation or closing of a covered establishment  
136 occurs, the employer of the covered establishment shall pay in full for  
137 the continuation of existing group health insurance, no matter where  
138 the group policy was written, issued or delivered, for each affected  
139 employee and his dependents, if covered under the group policy, from  
140 the date of relocation or closing for a period of one hundred twenty  
141 days or until such time as the employee becomes eligible for other  
142 group coverage, whichever is the lesser, provided any right of such

143 employee and his dependents to a continuation of coverage [for up to  
144 seventy-eight or one hundred fifty-six weeks, as the case may be,] as  
145 required by section 38a-538, as amended by this act, or 38a-554, as  
146 amended by this act, shall not be affected by the provisions of this  
147 section, and provided further the period of continued coverage  
148 required by said sections shall not commence until the period of  
149 continued coverage established by this section has terminated.

150 (b) The provisions of this section shall not apply to those employees  
151 who, upon the relocation or closing of a covered establishment, choose  
152 to continue their employment with the employer at the new location of  
153 the facility.

154 (c) Notwithstanding the provisions of this section, any contractual  
155 agreement arrived at through a collective bargaining process that  
156 contains provisions requiring the employer to pay for the continuation  
157 of existing group health insurance for his affected employees in the  
158 event of a relocation or closing of a covered establishment shall  
159 supersede the requirements of this section and, in the event of a  
160 conflict, the contractual provisions shall be deemed to be controlling.

161 Sec. 4. Section 38a-564 of the general statutes is repealed and the  
162 following is substituted in lieu thereof (*Effective from passage*):

163 As used in sections 12-201, 12-211, 12-212a, this section and [38a-  
164 564] sections 38a-565 to 38a-572, inclusive, as amended by this act:

165 (1) "Pool" means the Connecticut Small Employer Health  
166 Reinsurance Pool, established under section 38a-569.

167 (2) "Board" means the board of directors of the pool.

168 (3) "Eligible employee" means an employee who works on a full-  
169 time basis, with a normal work week of thirty or more hours and  
170 includes a sole proprietor, a partner of a partnership or an  
171 independent contractor, provided such sole proprietor, partner or  
172 contractor is included as an employee under a health care plan of a

173 small employer but does not include an employee who works on a  
174 part-time, temporary or substitute basis. "Eligible employee" shall  
175 include any employee who is not actively at work but is covered under  
176 the small employer's health insurance plan pursuant to workers'  
177 compensation, continuation of benefits pursuant to [federal extension  
178 requirements established by the Consolidated Omnibus Budget  
179 Reconciliation Act of 1985 (P.L. 99-272), as amended, (COBRA)] section  
180 38a-554, as amended by this act, or other applicable laws. [Such  
181 employees shall not be counted as eligible employees for the purposes  
182 of subsection (4) of this section.]

183 (4) (A) "Small employer" means any person, firm, corporation,  
184 limited liability company, partnership or association actively engaged  
185 in business or self-employed for at least three consecutive months  
186 who, on at least fifty per cent of its working days during the preceding  
187 twelve months, employed no more than fifty eligible employees, the  
188 majority of whom were employed within the state of Connecticut.  
189 "Small employer" includes a self-employed individual. [In] For the  
190 purposes of determining the number of eligible employees [,  
191 companies which] under this subdivision: (i) Companies that are  
192 affiliated companies, as defined in section 33-840, or [which] that are  
193 eligible to file a combined tax return for purposes of taxation under  
194 chapter 208 shall be considered one employer; [. Eligible employees  
195 shall not include] (ii) employees covered through the employer by  
196 health insurance plans or insurance arrangements issued to or in  
197 accordance with a trust established pursuant to collective bargaining  
198 subject to the federal Labor Management Relations Act shall not be  
199 counted; and (iii) employees who are not actively at work but are  
200 covered under the small employer's health insurance plan pursuant to  
201 workers' compensation, continuation of benefits pursuant to section  
202 38a-554, as amended by this act, or other applicable laws shall not be  
203 counted. Except as otherwise specifically provided, provisions of  
204 sections 12-201, 12-211, 12-212a, this section and [38a-564] sections 38a-  
205 565 to 38a-572, inclusive, that apply to a small employer shall continue  
206 to apply until the plan anniversary following the date the employer no

207 longer meets the requirements of this definition.

208 (B) "Small employer" does not include (i) a municipality procuring  
209 health insurance pursuant to section 5-259, (ii) a private school in this  
210 state procuring health insurance through a health insurance plan or an  
211 insurance arrangement sponsored by an association of such private  
212 schools, (iii) a nonprofit organization procuring health insurance  
213 pursuant to section 5-259, unless the Secretary of the Office of Policy  
214 and Management and the State Comptroller make a request in writing  
215 to the Insurance Commissioner that such nonprofit organization be  
216 deemed a small employer for the purposes of this chapter, (iv) an  
217 association for personal care assistants procuring health insurance  
218 pursuant to section 5-259, or (v) a community action agency procuring  
219 health insurance pursuant to section 5-259.

220 (5) "Insurer" means any insurance company, hospital or medical  
221 service corporation, or health care center, authorized to transact health  
222 insurance business in this state.

223 (6) "Insurance arrangement" means any "multiple employer welfare  
224 arrangement", as defined in Section 3 of the Employee Retirement  
225 Income Security Act of 1974 (ERISA), as amended from time to time,  
226 except for any such arrangement [which] that is fully insured within  
227 the meaning of Section 514(b)(6) of said act, as amended from time to  
228 time.

229 (7) "Health insurance plan" means any hospital and medical expense  
230 incurred policy, hospital or medical service plan contract and health  
231 care center subscriber contract and does not include (A) accident only,  
232 credit, dental, vision, Medicare supplement, long-term care or  
233 disability insurance, hospital indemnity coverage, coverage issued as a  
234 supplement to liability insurance, insurance arising out of a workers'  
235 compensation or similar law, automobile medical-payments insurance,  
236 or insurance under which beneficiaries are payable without regard to  
237 fault and which is statutorily required to be contained in any liability  
238 insurance policy or equivalent self-insurance, or (B) policies of

239 specified disease or limited benefit health insurance, provided that the  
240 carrier offering such policies files on or before March first of each year  
241 a certification with the commissioner that contains the following: (i) A  
242 statement from the carrier certifying that such policies are being  
243 offered and marketed as supplemental health insurance and not as a  
244 substitute for hospital or medical expense insurance; (ii) a summary  
245 description of each such policy including the average annual premium  
246 rates, or range of premium rates in cases where premiums vary by age,  
247 gender or other factors, charged for such policies in the state; and (iii)  
248 in the case of a policy that is described in this subparagraph and that is  
249 offered for the first time in this state on or after October 1, 1993, the  
250 carrier files with the commissioner the information and statement  
251 required in this subparagraph at least thirty days prior to the date such  
252 policy is issued or delivered in this state.

253 (8) "Plan of operation" means the plan of operation of the pool,  
254 including articles, bylaws and operating rules, adopted by the board  
255 pursuant to section 38a-569.

256 (9) "Late enrollee" means an eligible employee or dependent who  
257 requests enrollment in a small employer's health insurance plan  
258 following the initial enrollment period provided under the terms of the  
259 first plan for which such employee or dependent was eligible through  
260 such small employer, provided an eligible employee or dependent  
261 shall not be considered a late enrollee if (A) the request for enrollment  
262 is made within thirty days after termination of coverage provided  
263 under another group health insurance plan and if the individual had  
264 not initially requested coverage under such plan solely because he was  
265 covered under another group health insurance plan and coverage  
266 under that plan has ceased due to termination of employment, death of  
267 a spouse, or divorce, or due to that plan's involuntary termination or  
268 cancellation by its carrier for reasons other than nonpayment of  
269 premium, or (B) the individual is employed by an employer who offers  
270 multiple health insurance plans and the individual elects a different  
271 health insurance plan during an open enrollment period, or (C) a court

272 has ordered coverage be provided for a spouse or minor child under a  
273 covered employee's plan and request for enrollment is made within  
274 thirty days after issuance of such court order, or (D) if the request for  
275 enrollment is made within thirty days after the marriage of such  
276 employee or the birth or adoption of the first child by such employee  
277 after the later of the commencement of the employer's plan or the date  
278 the pool becomes operational, and satisfactory evidence of such  
279 marriage, birth or adoption is provided to the small employer carrier.

280 (10) "Department" means the Insurance Department.

281 (11) "Special health care plan" means a health insurance plan for  
282 previously uninsured small employers, established by the board in  
283 accordance with section 38a-565 or by the Health Reinsurance  
284 Association in accordance with section 38a-570.

285 (12) "Small employer health care plan" means a health insurance  
286 plan for small employers, established by the board in accordance with  
287 section 38a-568.

288 (13) "Dependent" means the spouse or child of an eligible employee,  
289 subject to applicable terms of the health insurance plan covering such  
290 employee. [Dependent] "Dependent" shall also include any dependent  
291 that is covered under the small employer's health insurance plan  
292 pursuant to workers' compensation, continuation of benefits pursuant  
293 to [federal extension requirements established by the Consolidated  
294 Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended,  
295 (COBRA)] section 38a-554, as amended by this act, or other applicable  
296 laws.

297 (14) "Commissioner" means the Insurance Commissioner.

298 (15) "Member" means each insurer and insurance arrangement  
299 participating in the pool.

300 (16) "Small employer carrier" means any insurer or insurance  
301 arrangement which offers or maintains group health insurance plans

302 covering eligible employees of one or more small employers.

303 (17) "Preexisting conditions provision" means a policy provision  
304 which excludes coverage for charges or expenses incurred during a  
305 specified period following the insured's effective date of coverage as to  
306 a condition which, during a specified period immediately preceding  
307 the effective date of coverage, had manifested itself in such a manner  
308 as would cause an ordinary prudent person to seek diagnosis, care or  
309 treatment or for which medical advice, diagnosis, care or treatment  
310 was recommended or received as to that condition or as to a condition  
311 which is pregnancy existing on the effective date of coverage.

312 (18) "Base premium rate" means, as to any health insurance plan or  
313 insurance arrangement covering one or more employees of a small  
314 employer, the lowest new business premium rate charged by the  
315 insurer or insurance arrangement for the same or similar coverage  
316 which is equivalent in value under a plan or arrangement covering any  
317 small employer with similar case characteristics, other than claim  
318 experience, as determined by such insurer or insurance arrangement,  
319 except that as to any small employer carrier or insurance arrangement  
320 not issuing new health insurance plans or insurance arrangements to a  
321 small employer, "base premium rate" means the lowest rate charged a  
322 small employer for the same or similar coverage which is equivalent in  
323 value, under a plan or arrangement covering any small employer with  
324 similar case characteristics, other than claim experience, as determined  
325 by such insurer or insurance arrangement.

326 (19) "Low-income eligible employee" means an eligible employee of  
327 a small employer whose annualized wages from such small employer  
328 determined as of the effective date of the special health care plan or as  
329 of any anniversary of such effective date as certified to the insurer or  
330 insurance arrangement or the Health Reinsurance Association, as the  
331 case may be, by such small employer is less than three hundred per  
332 cent of the federal poverty level applicable to such person.

333 (20) "Medicare" means the Health Insurance for the Aged Act, Title

334 XVIII of the Social Security Amendments of 1965, as amended from  
335 time to time.

336 (21) "Health Reinsurance Association" means the entity established  
337 and maintained in accordance with the provisions of sections 38a-505,  
338 38a-546 and 38a-551 to 38a-559, inclusive, as amended by this act.

339 (22) "Reimbursement rate" means, as to individuals covered under  
340 special health care plans or an individual special health care plan,  
341 seventy-five per cent of the Medicare reimbursement rate for benefits  
342 normally reimbursable under Medicare. For services or supplies not  
343 reimbursed by Medicare, such reimbursement shall be seventy-five per  
344 cent of the amount which would be payable under Medicare, if  
345 Medicare was responsible for benefit payments under such plans for  
346 such services and supplies, as determined by the board and approved  
347 by the commissioner.

348 (23) "Individual special health care plan" means a health insurance  
349 plan for individuals, issued by the Health Reinsurance Association in  
350 accordance with section 38a-571 or issued by an insurer in accordance  
351 with section 38a-565.

352 (24) "Low-income individual" means an individual whose adjusted  
353 gross income (AGI) for the individual and spouse, from the most  
354 recent federal tax return filed prior to the date of application for the  
355 individual special health care plan or prior to any anniversary of the  
356 effective date of the plan, as certified by such individual, is less than  
357 three hundred per cent of the applicable federal poverty level.

358 (25) "Medicare reimbursement rate" means the amount which  
359 would be payable under Medicare for benefits normally reimbursed  
360 under Medicare.

361 (26) "Health care center" means health care center as defined in  
362 section 38a-175.

363 (27) "Case characteristics" means demographic or other objective

364 characteristics of a small employer, including age, sex, family  
365 composition, location, size of group, administrative cost savings  
366 resulting from the administration of an association group plan or a  
367 plan written pursuant to section 5-259 and industry classification, as  
368 determined by a small employer carrier, that are considered by the  
369 small employer carrier in the determination of premium rates for the  
370 small employer. Claim experience, health status, and duration of  
371 coverage since issue are not case characteristics for the purpose of  
372 sections 38a-564 to 38a-572, inclusive, as amended by this act.

373 (28) "Actuarial certification" means a written statement by a member  
374 of the American Academy of Actuaries or other individual acceptable  
375 to the commissioner that a small employer carrier is in compliance  
376 with the provisions of subdivisions (4), (6), (7) and (9) of section 38a-  
377 567 and the regulations promulgated by the commissioner pursuant to  
378 [subdivision (8) of] section 38a-567, as amended by this act, based  
379 upon the person's examination, including a review of the appropriate  
380 records and of the actuarial assumptions and methods used by the  
381 small employer carrier in establishing premium rates for applicable  
382 health benefit plans.

383 Sec. 5. Section 38a-567 of the general statutes is repealed and the  
384 following is substituted in lieu thereof (*Effective from passage*):

385 Health insurance plans and insurance arrangements covering small  
386 employers and insurers and producers marketing such plans and  
387 arrangements shall be subject to the following provisions:

388 (1) (A) Any such plan or arrangement shall be renewable with  
389 respect to all eligible employees or dependents at the option of the  
390 small employer, policyholder or contractholder, as the case may be,  
391 except: (i) For nonpayment of the required premiums by the small  
392 employer, policyholder or contractholder; (ii) for fraud or  
393 misrepresentation of the small employer, policyholder or  
394 contractholder or, with respect to coverage of individual insured, the  
395 insureds or their representatives; (iii) for noncompliance with plan or

396 arrangement provisions; (iv) when the number of insureds covered  
397 under the plan or arrangement is less than the number of insureds or  
398 percentage of insureds required by participation requirements under  
399 the plan or arrangement; or (v) when the small employer, policyholder  
400 or contractholder is no longer actively engaged in the business in  
401 which it was engaged on the effective date of the plan or arrangement.

402 (B) Renewability of coverage may be effected by either continuing in  
403 effect a plan or arrangement covering a small employer or by  
404 substituting upon renewal for the prior plan or arrangement the plan  
405 or arrangement then offered by the carrier that most closely  
406 corresponds to the prior plan or arrangement and is available to other  
407 small employers. Such substitution shall only be made under  
408 conditions approved by the commissioner. A carrier may substitute a  
409 plan or arrangement as stated above only if the carrier effects the same  
410 substitution upon renewal for all small employers previously covered  
411 under the particular plan or arrangement, unless otherwise approved  
412 by the commissioner. The substitute plan or arrangement shall be  
413 subject to the rating restrictions specified in this section on the same  
414 basis as if no substitution had occurred, except for an adjustment  
415 based on coverage differences.

416 (C) Notwithstanding the provisions of this subdivision, any such  
417 plan or arrangement, or any coverage provided under such plan or  
418 arrangement may be rescinded for fraud, material misrepresentation  
419 or concealment by an applicant, employee, dependent or small  
420 employer.

421 (D) Any individual who was not a late enrollee at the time of his or  
422 her enrollment and whose coverage is subsequently rescinded shall be  
423 allowed to reenroll as of a current date in such plan or arrangement  
424 subject to any preexisting condition or other provisions applicable to  
425 new enrollees without previous coverage. On and after the effective  
426 date of such individual's reenrollment, the small employer carrier may  
427 modify the premium rates charged to the small employer for the

428 balance of the current rating period and for future rating periods, to  
429 the level determined by the carrier as applicable under the carrier's  
430 established rating practices had full, accurate and timely underwriting  
431 information been supplied when such individual initially enrolled in  
432 the plan. The increase in premium rates allowed by this provision for  
433 the balance of the current rating period shall not exceed twenty-five  
434 per cent of the small employer's current premium rates. Any such  
435 increase for the balance of said current rating period shall not be  
436 subject to the rate limitation specified in subdivision (6) of this section.  
437 The rate limitation specified in this section shall otherwise be fully  
438 applicable for the current and future rating periods. The modification  
439 of premium rates allowed by this subdivision shall cease to be  
440 permitted for all plans and arrangements on the first rating period  
441 commencing on or after July 1, 1995.

442 (2) Except in the case of a late enrollee who has failed to provide  
443 evidence of insurability satisfactory to the insurer, the plan or  
444 arrangement may not exclude any eligible employee or dependent  
445 who would otherwise be covered under such plan or arrangement on  
446 the basis of an actual or expected health condition of such person. No  
447 plan or arrangement may exclude an eligible employee or eligible  
448 dependent who, on the day prior to the initial effective date of the plan  
449 or arrangement, was covered under the small employer's prior health  
450 insurance plan or arrangement pursuant to workers' compensation,  
451 continuation of benefits pursuant to [federal extension requirements  
452 established by the Consolidated Omnibus Budget Reconciliation Act of  
453 1985 (P.L. 99-2721, as amended)] section 38a-554, as amended by this  
454 act, or other applicable laws. The employee or dependent must request  
455 coverage under the new plan or arrangement on a timely basis and  
456 such coverage shall terminate in accordance with the provisions of the  
457 applicable law.

458 (3) (A) For rating periods commencing on or after October 1, 1993,  
459 and prior to July 1, 1994, the premium rates charged or offered for a  
460 rating period for all plans and arrangements may not exceed one

461 hundred thirty-five per cent of the base premium rate for all plans or  
462 arrangements.

463 (B) For rating periods commencing on or after July 1, 1994, and prior  
464 to July 1, 1995, the premium rates charged or offered for a rating  
465 period for all plans or arrangements may not exceed one hundred  
466 twenty per cent of the base premium rate for such rating period. The  
467 provisions of this subdivision shall not apply to any small employer  
468 who employs more than twenty-five eligible employees.

469 (4) For rating periods commencing on or after October 1, 1993, and  
470 prior to July 1, 1995, the percentage increase in the premium rate  
471 charged to a small employer, who employs not more than twenty-five  
472 eligible employees, for a new rating period may not exceed the sum of:

473 (A) The percentage change in the base premium rate measured from  
474 the first day of the prior rating period to the first day of the new rating  
475 period;

476 (B) An adjustment of the small employer's premium rates for the  
477 prior rating period, and adjusted pro rata for rating periods of less  
478 than one year, due to the claim experience, health status or duration of  
479 coverage of the employees or dependents of the small employer, such  
480 adjustment (i) not to exceed ten per cent annually for the rating  
481 periods commencing on or after October 1, 1993, and prior to July 1,  
482 1994, and (ii) not to exceed five per cent annually for the rating periods  
483 commencing on or after July 1, 1994, and prior to July 1, 1995; and

484 (C) Any adjustments due to change in coverage or change in the  
485 case characteristics of the small employer, as determined from the  
486 small employer carrier's applicable rate manual.

487 (5) (A) With respect to plans or arrangements issued on or after July  
488 1, 1995, the premium rates charged or offered to small employers shall  
489 be established on the basis of a community rate, adjusted to reflect one  
490 or more of the following classifications:

491 (i) Age, provided age brackets of less than five years shall not be  
492 utilized;

493 (ii) Gender;

494 (iii) Geographic area, provided an area smaller than a county shall  
495 not be utilized;

496 (iv) Industry, provided the rate factor associated with any industry  
497 classification shall not vary from the arithmetic average of the highest  
498 and lowest rate factors associated with all industry classifications by  
499 greater than fifteen per cent of such average, and provided further, the  
500 rate factors associated with any industry shall not be increased by  
501 more than five per cent per year;

502 (v) Group size, provided the highest rate factor associated with  
503 group size shall not vary from the lowest rate factor associated with  
504 group size by a ratio of greater than 1.25 to 1.0;

505 (vi) Administrative cost savings resulting from the administration of  
506 an association group plan or a plan written pursuant to section 5-259,  
507 provided the savings reflect a reduction to the small employer carrier's  
508 overall retention that is measurable and specifically realized on items  
509 such as marketing, billing or claims paying functions taken on directly  
510 by the plan administrator or association, except that such savings may  
511 not reflect a reduction realized on commissions;

512 (vii) Savings resulting from a reduction in the profit of a carrier who  
513 writes small business plans or arrangements for an association group  
514 plan or a plan written pursuant to section 5-259 provided any loss in  
515 overall revenue due to a reduction in profit is not shifted to other small  
516 employers; and

517 (viii) Family composition, provided the small employer carrier shall  
518 utilize only one or more of the following billing classifications: (I)  
519 Employee; (II) employee plus family; (III) employee and spouse; (IV)  
520 employee and child; (V) employee plus one dependent; and (VI)

521 employee plus two or more dependents.

522 (B) The small employer carrier shall quote premium rates to small  
523 employers after receipt of all demographic rating classifications of the  
524 small employer group. No small employer carrier may inquire  
525 regarding health status or claims experience of the small employer or  
526 its employees or dependents prior to the quoting of a premium rate.

527 (C) The provisions of subparagraphs (A) and (B) of this subdivision  
528 shall apply to plans or arrangements issued on or after July 1, 1995.  
529 The provisions of subparagraphs (A) and (B) of this subdivision shall  
530 apply to plans or arrangements issued prior to July 1, 1995, as of the  
531 date of the first rating period commencing on or after that date, but no  
532 later than July 1, 1996.

533 (6) For any small employer plan or arrangement on which the  
534 premium rates for employee and dependent coverage or both, vary  
535 among employees, such variations shall be based solely on age and  
536 other demographic factors permitted under subparagraph (A) of  
537 subdivision (5) of this section and such variations may not be based on  
538 health status, claim experience, or duration of coverage of specific  
539 enrollees. Except as otherwise provided in subdivision (1) of this  
540 section, any adjustment in premium rates charged for a small  
541 employer plan or arrangement to reflect changes in case characteristics  
542 prior to the end of a rating period shall not include any adjustment to  
543 reflect the health status, medical history or medical underwriting  
544 classification of any new enrollee for whom coverage begins during  
545 the rating period.

546 (7) For rating periods commencing prior to July 1, 1995, in any case  
547 where a small employer carrier utilized industry classification as a case  
548 characteristic in establishing premium rates, the rate factor associated  
549 with any industry classification shall not vary from the arithmetical  
550 average of the highest and lowest rate factors associated with all  
551 industry classifications by greater than fifteen per cent of such average.

552 (8) Differences in base premium rates charged for health benefit  
553 plans by a small employer carrier shall be reasonable and reflect  
554 objective differences in plan design, not including differences due to  
555 the nature of the groups assumed to select particular health benefit  
556 plans.

557 (9) For rating periods commencing prior to July 1, 1995, in any case  
558 where an insurer issues or offers a policy or contract under which  
559 premium rates for a specific small employer are established or  
560 adjusted in part based upon the actual or expected variation in claim  
561 costs or actual or expected variation in health conditions of the  
562 employees or dependents of such small employer, the insurer shall  
563 make reasonable disclosure of such rating practices in solicitation and  
564 sales materials utilized with respect to such policy or contract.

565 (10) If a small employer carrier denies coverage as requested to a  
566 small employer that is self-employed, the small employer carrier shall  
567 promptly offer such small employer the opportunity to purchase a  
568 small employer health care plan. If a small employer carrier or any  
569 producer representing that carrier fails, for any reason, to offer  
570 coverage as requested by a small employer that is self-employed, that  
571 small employer carrier shall promptly offer such small employer an  
572 opportunity to purchase a small employer health care plan.

573 (11) No small employer carrier or producer shall, directly or  
574 indirectly, engage in the following activities:

575 (A) Encouraging or directing small employers to refrain from filing  
576 an application for coverage with the small employer carrier because of  
577 the health status, claims experience, industry, occupation or  
578 geographic location of the small employer, except the provisions of  
579 this subparagraph shall not apply to information provided by a small  
580 employer carrier or producer to a small employer regarding the  
581 carrier's established geographic service area or a restricted network  
582 provision of a small employer carrier; or

583 (B) Encouraging or directing small employers to seek coverage from  
584 another carrier because of the health status, claims experience,  
585 industry, occupation or geographic location of the small employer.

586 (12) No small employer carrier shall, directly or indirectly, enter into  
587 any contract, agreement or arrangement with a producer that provides  
588 for or results in the compensation paid to a producer for the sale of a  
589 health benefit plan to be varied because of the health status, claims  
590 experience, industry, occupation or geographic area of the small  
591 employer. A small employer carrier shall provide reasonable  
592 compensation, as provided under the plan of operation of the  
593 program, to a producer, if any, for the sale of a special or a small  
594 employer health care plan. No small employer carrier shall terminate,  
595 fail to renew or limit its contract or agreement of representation with a  
596 producer for any reason related to the health status, claims experience,  
597 occupation, or geographic location of the small employers placed by  
598 the producer with the small employer carrier.

599 (13) No small employer carrier or producer shall induce or  
600 otherwise encourage a small employer to separate or otherwise  
601 exclude an employee from health coverage or benefits provided in  
602 connection with the employee's employment.

603 (14) Denial by a small employer carrier of an application for  
604 coverage from a small employer shall be in writing and shall state the  
605 reasons for the denial.

606 (15) No small employer carrier or producer shall disclose (A) to a  
607 small employer the fact that any or all of the eligible employees of such  
608 small employer have been or will be reinsured with the pool, or (B) to  
609 any eligible employee or dependent the fact that he has been or will be  
610 reinsured with the pool.

611 (16) If a small employer carrier enters into a contract, agreement or  
612 other arrangement with another party to provide administrative,  
613 marketing or other services related to the offering of health benefit

614 plans to small employers in this state, the other party shall be subject  
615 to the provisions of this section.

616 (17) The commissioner may adopt regulations in accordance with  
617 the provisions of chapter 54 setting forth additional standards to  
618 provide for the fair marketing and broad availability of health benefit  
619 plans to small employers.

620 (18) Each small employer carrier shall maintain at its principal place  
621 of business a complete and detailed description of its rating practices  
622 and renewal underwriting practices, including information and  
623 documentation that demonstrates that its rating methods and practices  
624 are based upon commonly accepted actuarial assumptions and are in  
625 accordance with sound actuarial principles. Each small employer  
626 carrier shall file with the commissioner annually, on or before March  
627 fifteenth, an actuarial certification certifying that the carrier is in  
628 compliance with this part and that the rating methods have been  
629 derived using recognized actuarial principles consistent with the  
630 provisions of sections 38a-564 to 38a-573, inclusive, as amended by this  
631 act. Such certification shall be in a form and manner and shall contain  
632 such information, as determined by the commissioner. A copy of the  
633 certification shall be retained by the small employer carrier at its  
634 principle place of business. Any information and documentation  
635 described in this subdivision but not subject to the filing requirement  
636 shall be made available to the commissioner upon his request. Except  
637 in cases of violations of sections 38a-564 to 38a-573, inclusive, as  
638 amended by this act, the information shall be considered proprietary  
639 and trade secret information and shall not be subject to disclosure by  
640 the commissioner to persons outside of the department except as  
641 agreed to by the small employer carrier or as ordered by a court of  
642 competent jurisdiction.

643 (19) The commissioner may suspend all or any part of this section  
644 relating to the premium rates applicable to one or more small  
645 employers for one or more rating periods upon a filing by the small

646 employer carrier and a finding by the commissioner that either the  
647 suspension is reasonable in light of the financial condition of the  
648 carrier or that the suspension would enhance the efficiency and  
649 fairness of the marketplace for small employer health insurance.

650 (20) For rating periods commencing prior to July 1, 1995, a small  
651 employer carrier shall quote premium rates to any small employer  
652 within thirty days after receipt by the carrier of such employer's  
653 completed application.

654 (21) Any violation of subdivisions (10) to (16), inclusive, of this  
655 section and of any regulations established under subdivision (17) of  
656 this section shall be an unfair and prohibited practice under sections  
657 38a-815 to 38a-830, inclusive.

658 (22) (A) With respect to plans or arrangements issued pursuant to  
659 subsection (i) of section 5-259, at the option of the Comptroller, the  
660 premium rates charged or offered to small employers purchasing  
661 health insurance shall not be subject to this section, provided (i) the  
662 plan or plans offered or issued cover such small employers as a single  
663 entity and cover not less than three thousand employees on the date  
664 issued, (ii) each small employer is charged or offered the same  
665 premium rate with respect to each employee and dependent, and (iii)  
666 the plan or plans are written on a guaranteed issue basis.

667 (B) With respect to plans or arrangements issued by an association  
668 group plan, at the option of the administrator of the association group  
669 plan, the premium rates charged or offered to small employers  
670 purchasing health insurance shall not be subject to this section,  
671 provided (i) the plan or plans offered or issued cover such small  
672 employers as a single entity and cover not less than three thousand  
673 employees on the date issued, (ii) each small employer is charged or  
674 offered the same premium rate with respect to each employee and  
675 dependent, and (iii) the plan or plans are written on a guaranteed issue  
676 basis. In addition, such association group (I) shall be a bona fide group  
677 as set forth in the Employee Retirement and Security Act of 1974, (II)

678 shall not be formed for the purposes of fictitious grouping, as defined  
679 in section 38a-827, and (III) shall not issue any plan that shall cause  
680 undue disruption in the insurance marketplace, as determined by the  
681 commissioner.

682 Sec. 6. Section 17b-284 of the general statutes is repealed and the  
683 following is substituted in lieu thereof (*Effective from passage*):

684 (a) The Commissioner of Social Services may continue, within  
685 available appropriations, to provide Medicaid to employed persons  
686 who have conditions which prevent them from obtaining health  
687 insurance under an employer's group health insurance plan and who  
688 would otherwise be eligible for such medical assistance.

689 (b) The commissioner may pay under the Medicaid program, within  
690 available appropriations, the employee's share of health insurance  
691 under an employer's group health insurance plan for employees who  
692 would otherwise be eligible for medical assistance.

693 (c) The commissioner may pay under the Medicaid program, within  
694 available appropriations, the premiums for continued health insurance  
695 coverage under an employer's group health insurance plan, pursuant  
696 to [the federal Consolidated Omnibus Budget Reconciliation Act of  
697 1985, as amended,] section 38a-554, as amended by this act, for  
698 chronically ill and disabled persons who are no longer employed and  
699 would otherwise be eligible for Medicaid.

700 Sec. 7. Section 17b-299 of the general statutes is repealed and the  
701 following is substituted in lieu thereof (*Effective from passage*):

702 (a) The commissioner or, at the commissioner's discretion, the single  
703 point of entry servicer shall review applications for eligibility to  
704 determine whether applicants or employers of applicants have  
705 discontinued employer-sponsored dependent coverage for the purpose  
706 of participation in the HUSKY Plan, Part B.

707 (b) An application may be disapproved if it is determined that a

708 child to be covered under the HUSKY Plan, Part B was covered by an  
709 employer-sponsored insurance within the last two months. If the  
710 commissioner determines that the time period specified in this  
711 subsection is insufficient to effectively deter applicants or employers of  
712 applicants from discontinuing employer-sponsored dependent  
713 coverage for the purpose of participation in the HUSKY Plan, Part B,  
714 the commissioner may extend such period for a maximum of an  
715 additional two months.

716 (c) An application may be approved in cases where prior employer-  
717 sponsored coverage ended less than two months prior to the  
718 determination of eligibility for reasons unrelated to the availability of  
719 the HUSKY Plan, Part B, including, but not limited to:

720 (1) Loss of employment due to factors other than voluntary  
721 termination;

722 (2) Death of a parent;

723 (3) Change to a new employer that does not provide an option for  
724 dependent coverage;

725 (4) Change of address so that no employer-sponsored coverage is  
726 available;

727 (5) Discontinuation of health benefits to all employees of the  
728 applicant's employer;

729 (6) Expiration of the continuation of coverage periods [established  
730 by the Consolidated Omnibus Budget Reconciliation Act of 1985, (P.L.  
731 99-272) as amended from time to time, (COBRA)] set forth in sections  
732 38a-554, as amended by this act;

733 (7) Self-employment;

734 (8) Termination of health benefits due to a long-term disability;

735 (9) Termination of dependent coverage due to an extreme economic

736 hardship on the part of either the employee or the employer, as  
737 determined by the commissioner; or

738 (10) Substantial reduction in either lifetime medical benefits or  
739 benefit category available to an employee and dependents under an  
740 employer's health care plan.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>from passage</i>	38a-538
Sec. 2	<i>from passage</i>	38a-554
Sec. 3	<i>from passage</i>	31-51o
Sec. 4	<i>from passage</i>	38a-564
Sec. 5	<i>from passage</i>	38a-567
Sec. 6	<i>from passage</i>	17b-284
Sec. 7	<i>from passage</i>	17b-299

***Statement of Purpose:***

To extend the period for continuation of group health insurance coverage following certain qualifying events to thirty months.

*[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]*